



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE

DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

**REINSTATEMENT APPLICATION FOR CERTIFICATE TO PRACTICE
MEDICINE AND SURGERY IN THE STATE OF DELAWARE**

Please type or print all information.

IDENTIFICATION:

Name: _____
Last First Middle

Name (if different from above): _____

Mailing Address: _____
Last First Middle

City State Zip

Phone: (Home) _____ (Work) _____

Email Address: _____

Date of Birth (MM/DD/YY) ____/____/____ SSN ____-____-____

EDUCATION:

Medical Education:

School Location Dates Degree

If a graduate of a foreign medical school, please indicate your ECFMG number and complete the Request for Status Report of ECFMGSM Certification:

USMLE/ECFMG Identification Number: 0- - -

Applicant Name: _____

Post Graduate Training:

Hospital/Institution	Location	Dates	Specialty
----------------------	----------	-------	-----------

_____	_____	_____	_____
_____	_____	_____	_____

Area / Field of Specialization	Board eligible?	Board Certified?
--------------------------------	-----------------	------------------

_____	Yes () No ()	Yes () No ()
-------	----------------	----------------

_____	Yes () No ()	Yes () No ()
-------	----------------	----------------

_____	Yes () No ()	Yes () No ()
-------	----------------	----------------

1. Have you ever taken any of the following examinations: Yes () No ()
USMLE, FLEX, National Boards or State Boards?

Examination

Date Passed
Month/Year

ECFMG (Basic)

ECFMG (Clinical)

ECFMG (English)

FLEX Component 1

Flex Component 2

Pre- 1985 FLEX

USMLE Step 1

USMLE Step 2

USMLE Step 3

NBME Part 1

NBME Part 2

NBME Part 3

NBOME Part 1

NBOME Part 2

NBOME Part 3

SPEX

COMLEX Level 1

COMLEX Level 2

COMLEX Level 3

LMCC

*State Board Examination

Applicant Name: _____

*(Name of state board(s) where _____
examination was taken and passed)

2. Have you ever had a medical or professional license Yes () No ()
denied or revoked?

List all states in which you have **ever** been licensed (including training license):
State or Territory License # Effective Dates

3. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdictions? **If yes, submit a certified copy of your criminal history record.** Yes () No ()

4. Have you ever been professionally penalized for a drug related offense? Yes () No ()

5. Have you ever been professionally penalized or convicted of fraud? Yes () No ()

6. Have you ever violated the Medical Practice Act of another state? Yes () No ()

7. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another state? Yes () No ()

8. Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way? Yes () No ()

9. Are there any charges or complaints of any type including malpractice claims pending against you at present? Yes () No ()

10. Have you ever engaged in the practice of medicine without a license? Yes () No ()

11. Have you ever prescribed narcotic drugs unlawfully? Yes () No ()

12. Have you ever been convicted of a drug violation? Yes () No ()

Applicant Name: _____

13. Have you ever willfully violated the confidence of a patient? Yes () No ()

14. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceedings or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, governmental agency, professional organization, or licensing authority? Yes () No ()

14.a. Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a mental, emotional, or nervous disorder or condition) which impairs your judgment or in any way currently affects, or if untreated could affect, your ability to practice medicine in a fully competent and professional manner with safety to patients? If you answered yes, answer questions 13.b. and 13.c. If you answered no, continue on to question 14. Yes () No ()

14.b. Are such current conditions or impairments reduced or ameliorated because of ongoing treatment (with or without medication) or participation in a monitoring program or because of the field of practice, the setting, or the manner in which you have chosen to practice medicine? Yes () No ()

14.c. If you claim to have an mental or physical disability which limits your ability to practice medicine in a fully competent and professional manner with safety to patients, are you willing to accept a conditional or limited license to practice medicine if it is possible to accommodate such disability? Yes () No ()

15. Have you ever been denied a Drug Enforcement Agency (DEA) registration number or had one revoked or otherwise had your authority to write prescriptions limited or restricted? Yes () No ()

16. Do you agree to submit to an examination at Board expense should an examination be deemed necessary by the Executive Director of the Board of Medical Practice to determine if your physical and/or mental impairment presents a significant risk to the health or safety of patients or otherwise causes you not to be fully qualified to practice medicine in a competent and professional manner with safety to patients without limitations or accommodations? Yes () No ()

If you answered **YES** to any questions 2 - 15, or answered **NO** to question 16, please fully explain your answer(s) on a separate sheet(s) of paper, sign and swear to its truth before a notary, and attach it to this application. In addition, please provide any documentation from the state where this situation occurred, spelling out the issues, and any explanation you wish to provide.

The Board office must receive items submitted for the Board to consider at its meeting no later than two full business days before the meeting. In order to be considered at a Board

Applicant Name: _____

meeting, license applications must be complete two full business days before the meeting. A complete application is one that includes all required documentation and correct payment.

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your certification.

I, _____, swear that I am the person who executed this application; that the statements contained on this application are true in every respect; that I have not suppressed or withheld information that might affect this application; that I will abide by the laws and the ethical standards of this profession; and that I have read and understand this statement.

I further understand that by filing this application for a Certificate to Practice Medicine and Surgery in the State of Delaware, I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine if I have previously engaged in unprofessional conduct as defined in 24 Delaware Code §1731 or the Rules and Regulations of the Delaware Board of Medical Practice and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

Signature of Applicant

Date

Sworn to before me and subscribed in my presence this _____ day of _____, 20_____

Signature of Notary _____

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Practice any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware Board of Medical Practice or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Board of Medical Practice will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to (1) keep the information I have provided in this application current until such time as the Board has finally acted on it, and (2) to promptly provide any and all additional information requested by or on behalf of the Board.

Signature of Applicant

Date

Sworn to before me and subscribed in my presence this _____ day of

_____, 20_____

Signature of Notary